



PERRY MEMORIAL HOSPITAL

530 Park Avenue East, Princeton, Illinois 61356 *** Phone: 815/875-2811

Review Options for ED DISCHARGE INSTRUCTIONS REPORT v2

Physician:

Patient Name: **KRAMER MADELINE H** Patient Birthdate: **01/20/2013**

Patient MR#: **778905** Account #: **01446996** Visit Date: **06/05/2016**

Final Diagnosis

No documentation for this section.

Discharge Instructions

MASSIMILIAN JOHN A 06-05-2016 21:43

Your Diagnosis Is: Other rash possible uti

MASSIMILIAN JOHN A 06-05-2016 21:44

Your Diagnosis Is: Other rash possible uti

Disposition: Discharge to Home

Your Diagnosis Is: Other rash possible uti

Activity: Other get culture results 2 days with your dr- may need antibiotic

Routine Home Medication Change: No

Follow-up With Your Doctor After: 48 hours

Diagnosis Specific Education: Diagnosis related handout given

Activity: Other get culture results 2 days with your dr- may need antibiotic

Routine Home Medication Change: No, No

HANNA LYNETTE J 06-05-2016 21:53

Diet Restrictions: Resume your usual diet

Diet Order: Regular

Medications: You were given the following medications to take home with you NONE, Prescriptions given NONE

Diet Restrictions: Resume your usual diet

Treatments and Procedures

HANNA LYNETTE J 06-05-2016 21:53

Procedures / Tests Performed In ER: Lab test

Instructions:

The culture that was done today will not have an immediate report available. If there is a change in your treatment, you will be notified.

Home Medication

MASSIMILIAN JOHN A 06-05-2016 21:44

Routine Home Medication Change: No, No

HANNA LYNETTE J 06-05-2016 21:53

Medications: You were given the following medications to take home with you NONE, Prescriptions given NONE



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Discharge Medications

No documentation for this section.

Follow-Up / Referral

MASSIMILIAN JOHN A 06/05/2016 21:44

Follow-up With Your Doctor After: 48 hours

HANNA LYNETTE J 06/05/2016 21:53

Follow-up Appointments: Dr OF CHOICE

Patient Signature: Sign and date this document if you have received and understand your discharge instructions and plan of care.

Wound / Incision Care

No documentation for this section.

Interventions

HANNA LYNETTE J 06/05/2016 21:53

Pain/Fever: OVER THE COUNTER TYLENOL OR MOTRIN AS NEEDED-SEE OVER THE COUNTER PACKAGES FOR DOSES/FREQUENCIES

Fever Over 101 F / 38 C: Don't overdress child or use heavy cover

Education

HANNA LYNETTE J 06/05/2016 21:53

Education Given to Patient: Patient's responsibilities

Instructions:

-REST

-PUSH FLUIDS

-GOOD HAND HYGIENE

-SEE YOUR DOCTOR OR RETURN TO EMERGENCY DEPARTMENT FOR NEW OR WORSENING SYMPTOMS

-TAKE MEDICATION AS PRESCRIBED

-DISCHARGE TIMEOUT PERFORMED

-ANY ABNORMAL VITAL SIGNS REPORTED TO PHYSICIAN AND RECONCILED PRIOR TO DISCHARGE

-EDUCATION REGARDING DIAGNOSIS GIVEN AND REVIEWED WITH PATIENT/FAMILY. PATIENT/FAMILY STATE UNDERSTANDING EDUCATION INFORMATION GIVEN.

Education Documents



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HANNA LYNETTE J 06/05/2016 21:54

Acute Rash

Diaper Rash

Urinary Tract Infection in Children

Resources

No documentation for this section.

PRINT DATE: 10/18/16 058
Medical Director:
Dr. Elizabeth Bauer-Marsh
TIME: 15:55

PERRY MEMORIAL HOSPITAL
530 Park Ave. East
Princeton, Illinois 61356
LABORATORY

PAGE 1
CLIA # 14D0431087

-- COMPARATIVE REPORT

P.: KRAMER MADELINE H
ACCT#: 01446996
ROOM.: ED106 DISCH 06/05/16 - NO PENDING ORDERS
ADMIT: 06/05/16

SEX.....: F
AGE.....: 3 Y
DOB.....: 01/20/2013
PAT. PHONE: 8158767479
MR#.....: 778905

ATTENDING: MASSIMILIAN JOHN A
SECOND...: NO DOCTOR
PRIM CARE.:

URINALYSIS

		06/05/16	REFERENCE
		2115	RANGE UNITS
Color	lt yellow		Normal:clrls-Dk.Yel
Clarity	clear		Normal: Clear
Glucose	norm		Normal: 0-25
Bilirubin	neg		Normal: Negative
Ketones	neg		Normal: 0-5
Sp.Gravity	1.010		Normal:1.003-1.029
Blood	neg		Normal: 0-5
pH	7.0		5.0 - 7.0
Protein	Negative		Normal: 0-20
Urobilinogen	norm		Normal: 0-1
Nitrite	Negative		Normal: Negative
Leukocytes	500 H		Normal: 0-10
Wbc	16-20 A		Normal: 0-5
Rbc	<1		Normal: 0-2
Epithelial	1-2		Normal: 0-5
Bacteria	FEW A		Normal:None Seen
Fus	SLIGHT		
Stals Type	NONE SEEN		
COMMENT	WITH CLUMPING		

MICROBIOLOGY

--ORDERED--	--COLLECTED--	--REC'D--	--RESULTED--	--VERIFIED--
6/05/16 2130	6/05/16 2115	6/05/16 2120	6/08/16 1214	6/08/16 1214
MLM	LJH	MLM	JLK	JLK

URINE CULTURE

MICROBIOLOGY REPORT

** FINAL **

Antimicrobial Susceptibility and Organism Identification Report

Specimen Number	19478	Requested :	06/05/16
Specimen Source	CLEAN VOID URINE	Collected :	06/05/16 21:15
Ward of Isolation	EMERGENCY DEPT.	Received :	06/05/16 21:20
Requesting Physician	MASSIMILIA, JOHN		

Patient/Specimen Tests and Comments

Specimen Comments

CULTURE RESULTS:
NO GROWTH 60 HR

Tech :
Date : / / :

Source : CLEAN VOID URINE
Collected : 06/05/16 21:15

ID # : 01446996

** FINAL **

PRINT DATE: 10/18/16 058
Medical Director:
Dr. Elizabeth Bauer-Marsh
TIME: 15:55

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PAGE 2
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-- COMPARATIVE REPORT

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ACCT#: 01446996
ROOM.: ED106 DISCH 06/05/16 - NO PENDING ORDERS
ADMIT: 06/05/16

SEX.....: F
AGE.....: 3 Y
DOB.....: 01/20/2013
PAT. PHONE: 8158767479
MR#.....: 778905

ATTENDING: MASSIMILIAN JOHN A
SECOND...: NO DOCTOR
PRIM CARE.:

MICROBIOLOGY



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Final Diagnosis

No documentation for this section.

Discharge Instructions

ED Discharge Instructions

Follow-up With Your Doctor After: 48 hours

Follow-up Appointments: Dr OF CHOICE

Patient Signature: Sign and date this document if you have received and understand your discharge instructions and plan of care.

Rash

Medications: None Reported

Disposition: Discharge to Home, Follow-Up with PMD

Your Diagnosis Is: Other rash possible uti

Disposition: Discharge to Home

Your Diagnosis Is: Other rash possible uti

Activity: Other get culture results 2 days with your dr- may need antibiotic

Routine Home Medication Change: No

Follow-up With Your Doctor After: 48 hours

Diagnosis Specific Education: Diagnosis related handout given

Activity: Other get culture results 2 days with your dr- may need antibiotic

Routine Home Medication Change: No, No

Diet Restrictions: Resume your usual diet

Diet Order: Regular

Medications: You were given the following medications to take home with you NONE, Prescriptions given NONE

Treatments and Procedures

Procedures / Tests Performed In ER: Lab test

Instructions:

The culture that was done today will not have an immediate report available. If there is a change in your treatment, you will be notified.

Home Medications

No documentation for this section.

Home Medication

Routine Home Medication Change: No, No

Medications: You were given the following medications to take home with you NONE, Prescriptions given NONE



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Discharge Medications

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Follow-Up / Referral

Follow-up With Your Doctor After: 48 hours

Follow-up Appointments: Dr OF CHOICE

Patient Signature: Sign and date this document if you have received and understand your discharge instructions and plan of care.

Wound / Incision Care

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Interventions

Pain/Fever: OVER THE COUNTER TYLENOL OR MOTRIN AS NEEDED-SEE OVER THE COUNTER PACKAGES FOR DOSES/FREQUENCIES

Fever Over 101 F / 38 C: Don't overdress child or use heavy cover

Education

Education Given to Patient: Patient's responsibilities

Instructions:

- REST
- PUSH FLUIDS
- GOOD HAND HYGIENE
- SEE YOUR DOCTOR OR RETURN TO EMERGENCY DEPARTMENT FOR NEW OR WORSENING SYMPTOMS
- TAKE MEDICATION AS PRESCRIBED
- DISCHARGE TIMEOUT PERFORMED
- ANY ABNORMAL VITAL SIGNS REPORTED TO PHYSICIAN AND RECONCILED PRIOR TO DISCHARGE
- EDUCATION REGARDING DIAGNOSIS GIVEN AND REVIEWED WITH PATIENT/FAMILY. PATIENT/FAMILY STATE UNDERSTANDING EDUCATION INFORMATION GIVEN.

Education Documents

Acute Rash

Diaper Rash

Urinary Tract Infection in Children

Resources

No documentation for this section.



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ED PHYSICIAN REPORT

Physician: John A Massimilian, DO

Patient Name: **KRAMER MADELINE H** Patient Birthdate: **01/20/2013**
Patient MR#: **778905** Account #: **01446996** Visit Date: **06/05/2016**

Chief Complaint and Reason for Visit

RASH

Allergies

KATHERINE A LONG

No Known Drug Allergies: Normal Active

History Present Illness

Rash

HANNA LYNETTE J 06/05/2016 20:33

Means of Arrival: Automobile, On Foot, ACCOMPANIED BY MOTHER

MASSIMILIAN JOHN A 06/05/2016 20:34

Chief Complaint: Rash

Means of Arrival: On Foot

History Reported By: Mother

Note:

mother just noticed asymptomatic groin rash tonight when pt returned from 4 days with father- NO SX, no meds or known trauma or urinary sx. No fever chills or any complaints from child.

MASSIMILIAN JOHN A 06/05/2016 21:00

History/Exam Limitations: None Reported

Brief Description:

MOTHER PICKED CHILD UP AFTER SPENDING 4 DAY VISITATION WITH DAD

MOTHER STATES "ITS RED AND INFLAMMED DOWN THERE"

MOTHER UNWILLING TO ALLOW NURSE "TO EXAMINE HER DOWN THERE"

CHILD IS ALERT AND ACTIVE

NO DISTRESS

RESPIRATIONS EASY

NO COMPLAINTS

Note:

mother then reports pt has had several groin ? yeast/ ? urine infections down there in the past- she is very uncertain. Pt may have had urine burn/ groin sore sx ???

Health History

Social History

Never smoker

Review of Systems

MASSIMILIAN JOHN A 06/05/2016 21:00

Constitutional: None Reported



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Patient MR#: **778905** Account #: **01446996** Visit Date: **06/05/2016**

Respiratory: None Reported

Gastrointestinal: None Reported

Genitourinary:

Symptoms include: irritation/rash

Musculoskeletal: None Reported

Skin/Breast:

Symptoms include: Rash

Hematologic/Lymphatic: None Reported

Allergic/Immunologic: None Reported

Medication(s)

No documentation for this section.

Physical Exam

Constitutional

MASSIMILIAN JOHN A 06/05/2016 21:00

Appearance Common Findings: Alert, Well Appearing, NAD

Thorax and Lungs

MASSIMILIAN JOHN A 06/05/2016 21:00

Chest Exam Common Findings: Chest Normal Appearance, CTA Bilaterally, Normal Respiratory Rate

Cardiovascular

MASSIMILIAN JOHN A 06/05/2016 21:00

Cardiac Exam Common Findings: Normal Cardiac Exam (RRR, No M/G/R), Regular Rate and Rhythm, Normal Rate

Abdomen

MASSIMILIAN JOHN A 06/05/2016 21:00

Abdomen Exam Common Findings: Soft, Non-Tender, No Mass, No HSM, Normal Bowel Sounds, Non-Tender, Non-Distended

Genitourinary

MASSIMILIAN JOHN A 06/05/2016 21:00

Note:

no overt traumas or injury- some mucoid material edges of labia- no signs of acute infection/ discharge/ drainage/ hymen trauma or problems. No worrisome findings at all- some vague minor dull red irritation groin labia area. does not look worrisome traumatic or any significant rash just non focal minor local irritation.

Neurologic

MASSIMILIAN JOHN A 06/05/2016 21:00

Note:



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alert, nl neuro for age, MAE. happy smiling playful w mom.

Order Results LABORATORY

CULTURE/SENS: IF INDICATED Collect:06/05/2016 21:15

Color lt yellow Collect:06/05/2016 21:15

Clarity clear Collect:06/05/2016 21:15

Glucose norm Collect:06/05/2016 21:15

Bilirubin neg Collect:06/05/2016 21:15

Ketones neg Collect:06/05/2016 21:15

Sp.Gravity 1.010 Collect:06/05/2016 21:15

Blood neg Collect:06/05/2016 21:15

H 7.0 Collect:06/05/2016 21:15 L=5.0 H=7.0

rotein Negative Collect:06/05/2016 21:15

Urobilinogen norm Collect:06/05/2016 21:15

Nitrite Negative Collect:06/05/2016 21:15

Leukocytes 500 Collect:06/05/2016 21:15

Wbc 16-20 Collect:06/05/2016 21:15

Rbc <1 Collect:06/05/2016 21:15

Epithelial 1-2 Collect:06/05/2016 21:15

Bacteria FEW Collect:06/05/2016 21:15

Mucous SLIGHT Collect:06/05/2016 21:15

Crystals Type NONE SEEN Collect:06/05/2016 21:15

Assessment

No documentation for this section.

Plan

Rash

MASSIMILIAN JOHN A 06/05/2016 21:43

Medications: None Reported

Disposition: Discharge to Home, Follow-Up with PMD

Your Diagnosis Is: Other rash possible uti

ED Procedures

No documentation for this section.

Problems



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ED PHYSICIAN REPORT

Physician: John A Massimilian, DO

Patient Name: **KRAMER MADELINE H** Patient Birthdate: **01/20/2013**
Patient MR#: **778905** Account #: **01446996** Visit Date: **06/05/2016**

No documentation for this section.

Electronically Signed By: John A Massimilian, DO 06/05/2016 22:05:40



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ED SUMMARY REPORT

Physician:

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Patient MR#: **778905** Account #: **01446996** Visit Date: **06/05/2016**

Chief Complaint and Reason for Visit

RASH

Allergies

KATHERINE A LONG

No Known Drug Allergies: Normal Active

Health History

No documentation for this section.

Medication(s)

No documentation for this section.

Vital Signs

Vital Signs/Height/Weight/O2 Therapy

(LJH, RN) 06/05/2016 20:33

Pain Scale 0

Pain Scale 0

(JMR, CNA) 06/05/2016 20:40

Weight ~~176 lbs 79.83 kg 79832.3 g~~ **Stated** -- Amended by (JMR, CNA) at 06/05/2016 20:52

BMI ~~29.29~~ -- Amended by (JMR, CNA) at

BSA ~~1.91~~ -- Amended by (JMR, CNA) at

Height ~~65.00 inches 165.1 cm~~ -- Amended by (JMR, CNA) at

Weight 31 lbs 14.06 kg 14061.4 g Floor Scale

Temperature 97.7 F 36.5 C Oral

Respiration ~~16~~ -- Amended by (JMR, CNA) at 06/05/2016 20:51

Respiration 24

Pulse ~~60 Radial~~ -- Amended by (JMR, CNA) at 06/05/2016 20:51

Pulse 130 Radial

O2 Sat 96 %

Method Room Air 21%

Blood Pressure ~~122/70 Sitting Right Arm~~ -- Amended by (JMR, CNA) at 06/05/2016 20:51

(LJH, RN) 06/05/2016 22:00

Pain Scale 0

Order Results

LABORATORY

06/05/2016 21:15

CULTURE/SENS: IF INDICATED Collect:06/05/2016 21:15



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Color lt yellow Collect:06/05/2016 21:15
Clarity clear Collect:06/05/2016 21:15
Glucose norm Collect:06/05/2016 21:15
Bilirubin neg Collect:06/05/2016 21:15
Ketones neg Collect:06/05/2016 21:15
Sp.Gravity 1.010 Collect:06/05/2016 21:15
Blood neg Collect:06/05/2016 21:15
pH 7.0 Collect:06/05/2016 21:15 L=5.0 H=7.0
Protein Negative Collect:06/05/2016 21:15
Urobilinogen norm Collect:06/05/2016 21:15
Nitrite Negative Collect:06/05/2016 21:15
Leukocytes 500 Collect:06/05/2016 21:15
Wbc 16-20 Collect:06/05/2016 21:15
Rbc <1 Collect:06/05/2016 21:15
Epithelial 1-2 Collect:06/05/2016 21:15
Bacteria FEW Collect:06/05/2016 21:15
Mucous SLIGHT Collect:06/05/2016 21:15
Crystals Type NONE SEEN Collect:06/05/2016 21:15

Orders Nursing

No documentation for this section.

Documentation

MASSIMILIAN JOHN A 06/05/2016 21:43

Medications: None Reported

Disposition: Discharge to Home, Follow-Up with PMD

Your Diagnosis Is: Other rash possible uti

HANNA LYNETTE J 06/05/2016 20:33

Means of Arrival: Automobile, On Foot, ACCOMPANIED BY MOTHER

General: Bed in low position, Call light in reach, Head of bed elevated, Side rails up x 1, MOTHER SITTING NEXT TO CHILD ON CART

Disposition: To room 106

ED Arrival Date/Time: 06/05/2016 20:32:00

Triage Date/Time: 06/05/2016 20:34

Time Physician Notified: 20:34

Time Physician Arrived to ED: 19:00

Is This A Trauma Case: No

Stress: NAD

Triage Level: 5 - Non-urgent

Date of Symptom Onset: 06/05/2016



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Brief Description:

MOTHER PICKED CHILD UP AFTER SPENDING 4 DAY VISITATION WITH DAD
MOTHER STATES "ITS RED AND INFLAMMED DOWN THERE"
MOTHER UNWILLING TO ALLOW NURSE "TO EXAMINE HER DOWN THERE"
CHILD IS ALERT AND ACTIVE
NO DISTRESS
RESPIRATIONS EASY
NO COMPLAINTS

Are You on Hospice: No

Work Relatedness: Not Work Related

Treatment Prior to Arrival: None

Means of Arrival: Automobile, On Foot, ACCOMPANIED BY MOTHER

GCS Assessment: Yes

Eyes: 4 - Open spontaneously

Verbal: 5 - Oriented

Motor: 6 - Obeys commands for movement

Total Score: 15

Pain Scale(s) Utilized: Pain Scale (0-10)

Pain Scale (0-10): 0 - No Pain

Pain Location: No pain indicated

Clinical Observation of Pain: Relaxed, calm expression

Primary Care Provider: Denies

Appearance Common Findings: Age Appropriate Behavior, Alert, Well Appearing, NAD

History Reported By: Mother

Preferred Language for Healthcare: English

Interpreter Called: No

Symptoms: None Reported

Airway: Widely Patent

Respiratory Rate: Normal Respiratory Rate

Symptoms: None Reported

Symptoms: None Reported

Symptoms:

Include: "RED, INFLAMMED" PERINEAL AREA

Do not include: Nocturia, Urinary Frequency, Daytime Urinary Frequency, Weak Urinary Stream, Urinary Hesitancy, Urinary Intermittency, Straining to Void, Incomplete Bladder Emptying, Postvoid Dribbling, Urinary Urgency, Enuresis, Urinary Incontinence, Dysuria, Hematuria, Foul Smelling Urine, Fever, Flank Pain, Abdominal Pain, Nausea, Vomiting, Irritability, Lethargy, Constipation

Musculoskeletal: None Reported

Assessments Performed: None

Symptoms:

Include: Skin Erythema



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Do not include: Dry Skin, Excoriations, Fine Scales, Fissures, Skin Pain, Pruritus, Anxiety, Fever, Swelling, Chills, Warmth, Skin Drainage

Skin Exam Common Findings: Normal Color, No Rash/Suspicious Lesion

Skin Color: Normal

Skin Temperature/Moisture: Warm and Dry

Pain Scale (0-10): 0 - No Pain

Pain Scale (0-10): 0 - No Pain

Note:

RN ASSESSMENT IN TRIAGE

BRIEF VERBAL COMMUNICATION WITH MOTHER

MOTHER IS UNSURE "IF I REALLY WANT HER EXAMINED DOWN THERE"

DR MASS EXPLAINED TO MOTHER THAT THERE WAS NO WAY TO DETERMINE TYPE OF RASH WITH OUT LOOKING AT PERINEAL AREA

PATIENT TRIAGED TO ROOM 6

Additional Pain Scales: POSS

1-POSS Scale: 1= Awake and alert

Clinical Observation of Pain: Relaxed, calm expression

Pain Location: No pain indicated

Neurological: None Reported

Level of Consciousness: Alert, Awake, Interactive

Orientation: Oriented to Person/Place/Time

Infection Risk Screen: Yes

Potential of Ebola Virus Disease Exposure: No known exposure

Pt Traveled Outside US Within 10 Days: No

Negative Isolation: Yes

Isolation Precautions: N/A

Advance Directives:

Do not include: Living Will, Durable POA for Health Care, Advance Directives on File

Religious Preference: Unknown

Identified Barriers: Able to learn new info, Other: MOTHER

Method of Learning Preferred by Patient: Written/printed material, MOTHER

Method Instructions Were Provided: Written/printed material, MOTHER

Persons Involved: Parent, Mother

Education Outcome: Actively participated, MOTHER

Patient Verbalizes Understanding and Agrees: MOTHER

Immunization Status: Up to Date, MOTHER STATES ALL IMMUNIZATIONS ARE UP TO DATE TO THIS AGE

Abuse History Screen: Yes

Domestic Violence Screen: No needs identified

Neglect: Yes, describe MOTHER CONCERNED THAT CHILD'S PERINEAL AREA IS "RED AND INFLAMMED" AFTER HAVING A 4 DAY VISITATION WITH HER FATHER



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Cultural Concerns: None, Yes, describe NO RELIGIOUS OR CULTURAL PRACTICES THAT MAY AFFECT TREATMENT

Sepsis Screen: Yes

Actual or Suspected Infection: None

SEPSIS: CRITERIA NOT MET; no actual or suspected infection

Time Zero - Screening Outcome: SEPSIS criteria met

Setting or Context of Time Zero: ED triage

Complaint Suggestive of New Infection: No

Identified Barriers: Able to learn new info, Other: MOTHER

Method of Learning Preferred by Patient: Written/printed material, MOTHER

Method Instructions Were Provided: Written/printed material, MOTHER

Persons Involved: Parent, Mother

Education Outcome: Actively participated, MOTHER

Patient Verbalizes Understanding and Agrees: MOTHER

MASSIMILIAN JOHN A 06/05/2016 20:34

Chief Complaint: Rash

Means of Arrival: On Foot

History Reported By: Mother

Note:

mother just noticed asymptomatic groin rash tonight when pt returned from 4 days with father- NO SX, no meds or known trauma or urinary sx. No fever chills or any complaints from child.

Means of Arrival: On Foot

HANNA LYNETTE J 06/05/2016 20:50

Note:

PHYSICAL EXAM PER DR MASS WITH RN PRESENT

PERINEAL AREA (BETWEEN LABIA AND AROUND VAGINAL ENTERANCE) REDDENED. NO VAGINAL DRAINAGE.

HYMEN INTACT

MASSIMILIAN JOHN A 06/05/2016 21:00

History/Exam Limitations: None Reported

Brief Description:

MOTHER PICKED CHILD UP AFTER SPENDING 4 DAY VISITATION WITH DAD

MOTHER STATES "ITS RED AND INFLAMMED DOWN THERE"

MOTHER UNWILLING TO ALLOW NURSE "TO EXAMINE HER DOWN THERE"

CHILD IS ALERT AND ACTIVE

NO DISTRESS

RESPIRATIONS EASY

NO COMPLAINTS

Note:

mother then reports pt has had several groin ? yeast/ ? urine infections down there in the past- she is very uncertain. Pt may have had urine m/ groin sore sx ???

Constitutional: None Reported

Respiratory: None Reported



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Patient MR#: **778905** Account #: **01446996** Visit Date: **06/05/2016**

Gastrointestinal: None Reported

Genitourinary:

Symptoms include: irritation/rash

Musculoskeletal: None Reported

Skin/Breast:

Symptoms include: Rash

Hematologic/Lymphatic: None Reported

Allergic/Immunologic: None Reported

Appearance Common Findings: Alert, Well Appearing, NAD

Chest Exam Common Findings: Chest Normal Appearance, CTA Bilaterally, Normal Respiratory Rate

Cardiac Exam Common Findings: Normal Cardiac Exam (RRR, No M/G/R), Regular Rate and Rhythm, Normal Rate

Abdomen Exam Common Findings: Soft, Non-Tender, No Mass, No HSM, Normal Bowel Sounds, Non-Tender, Non-Distended

Note:

no overt traums or injury- some mucoid material edges of labia- no signs of acute infection/ discharge/ drainage/ hymen trauma or problems. No worrisome findings at all- some vague minor dull red irritation groin labia area. does not look worrisome traumatic or any significant rash just non focal minor local irritation.

Note:

alert, nl neuro for age, MAE. happy smiling playful w mom.

HANNA LYNETTE J 06/05/2016 21:00

Note:

APPLE JUICE ORALLY

MOTHER INSTRUCTED ON CLEAN CATCH URINE SAMPLE PROCEDURE

HANNA LYNETTE J 06/05/2016 21:15

Note:

URINE SAMPLE OBTAINED AND SENT TO LAB

MASSIMILIAN JOHN A 06/05/2016 21:33

Initial Impression: Rash, Uncertain Etiology

Current Condition: Mild

ED Testing: ua

Medications: None Reported

Treatment Response: Improved Condition

HANNA LYNETTE J 06/05/2016 21:40

Note:

MOTHER UPDATED THAT URINALYSIS RESULTS ARE COMPLETE

DR MASS NOTIFIED UA RESULTS ARE COMPLETE

MASSIMILIAN JOHN A 06/05/2016 21:44

Follow-up With Your Doctor After: 48 hours

Disposition: Discharge to Home

Our Diagnosis Is: Other rash possible uti

Activity: Other get culture results 2 days with your dr- may need antibiotic



PERRY MEMORIAL HOSPITAL

530 Park Avenue East, Princeton, Illinois 61356 *** Phone: 815/875-2811

ED SUMMARY REPORT

Physician:

Patient Name: **KRAMER MADELINE H** Patient Birthdate: **01/20/2013**

Patient MR#: **778905** Account #: **01446996** Visit Date: **06/05/2016**

Routine Home Medication Change: No

Follow-up With Your Doctor After: 48 hours

Diagnosis Specific Education: Diagnosis related handout given

Activity: Other get culture results 2 days with your dr- may need antibiotic

Routine Home Medication Change: No, No

HANNA LYNETTE J 06/05/2016 21:45

Note:

RE-EXAM DR MASS

HANNA LYNETTE J 06/05/2016 21:53

Follow-up Appointments: Dr OF CHOICE

Patient Signature: Sign and date this document if you have received and understand your discharge instructions and plan of care.

Pain/Fever: OVER THE COUNTER TYLENOL OR MOTRIN AS NEEDED-SEE OVER THE COUNTER PACKAGES FOR DOSES/FREQUENCIES

Over 101 F / 38 C: Don't overdress child or use heavy cover

Education Given to Patient: Patient's responsibilities

Instructions:

- REST
- PUSH FLUIDS
- GOOD HAND HYGIENE
- SEE YOUR DOCTOR OR RETURN TO EMERGENCY DEPARTMENT FOR NEW OR WORSENING SYMPTOMS
- TAKE MEDICATION AS PRESCRIBED
- DISCHARGE TIMEOUT PERFORMED
- ANY ABNORMAL VITAL SIGNS REPORTED TO PHYSICIAN AND RECONCILED PRIOR TO DISCHARGE
- EDUCATION REGARDING DIAGNOSIS GIVEN AND REVIEWED WITH PATIENT/FAMILY. PATIENT/FAMILY STATE UNDERSTANDING EDUCATION INFORMATION GIVEN.

Diet Restrictions: Resume your usual diet

Diet Order: Regular

Medications: You were given the following medications to take home with you NONE, Prescriptions given NONE

Procedures / Tests Performed In ER: Lab test

Instructions:

The culture that was done today will not have an immediate report available. If there is a change in your treatment, you will be notified.

HANNA LYNETTE J 06/05/2016 22:00

Disposition: Discharged

Critical Care Time: Not Applicable

Pain Scale (0-10): 0 - No Pain

Pain Location: No pain indicated

Clinical Observation of Pain: Relaxed, calm expression

Discharged To: Home

Discharged Via: Ambulatory, Private auto

Instructions Given to: Parent, mother



PERRY MEMORIAL HOSPITAL
530 Park Avenue East, Princeton, Illinois 61356 *** Phone: 815/875-2811

ED SUMMARY REPORT

Physician:

Patient Name: **KRAMER MADELINE H** Patient Birthdate: **01/20/2013**
Patient MR#: **778905** Account #: **01446996** Visit Date: **06/05/2016**

Verbalizes Understanding Instructions: Yes, MOTHER

Prescriptions: N/A

Accompanied by: Parent, mother

Car Seat for Child: Car seat required - child is less than 8 years old / less than 4 ft. 9 in.

Date/Time of Discharge: 06/05/2016 22:00

Pain Scale (0-10): 0 - No Pain

Clinical Observation of Pain: Relaxed, calm expression

Pain Location: No pain indicated

MASSIMILIAN JOHN A 06/05/2016 22:03

Note:

UA abnormal- suspect contamination will culture and refer for follow up- IF POS mom understands will need AB RX

Perry Memorial Hospital Emergency Department Triage

Acct #: 01333591 MR #: 778905 AGE: 9M DOB: 01202013 DATE: 111813 AdvDir N
 PATIENT: KRAMER MADELINE H Admit Phys CERNOVICH Second Phys: NO DOCTOR

CHIEF COMPLAINT PERINEUM RED

Emergency Severity Index: Non-emergent

Pain level 0 ☐ Animal Bite

Triage Date: 11182013 Triage Time: 0852 Triage Nurse: Kathy M., RN Triage location: Room 2

Time to Waiting Mode of Arrival: Carried Accompanied by: Parent EMS Service:

☐ LWBS

☐ MVC ☐ Pre-Hospital Care:

Critical Care Start Time

Triage Notes

Height & Weight 18 lbs oz 8.16 kg 8164.7 g 26 in .39 m2 0

Height & Weight New

Vital Signs

Temperature	Pulse	Respiration	Blood Pressure	O2 Saturation
98 TEMPORAL SCANNING	136 APICAL	24	110/R ARM LYING	98

New

NOTES:

MOTHER GIVES HX OF CHILD'S FATHER WATCHING THE CHILD YESTERDAY AND WHEN THE MOTHER CHANGED THE BABY'S DIAPER TODAY, PERINEUM RED. MOTHER CONCERNED AND WANTS CHILD SEEN. PERINEUM IS RED. NO BLEEDING NOTED.

☐ MORE Notes

Allergies

see E-MAR for allergy reaction information

ALLERGY

No Known Drug Allergies

ALLERGY

☐ MORE Allergies

Mental Status	Skin	Respirations	Psychosocial
☒ Alert ☐ Oriented x3 ☐ Confused/Disoriented	☒ Warm ☐ Cool ☐ Hot ☒ Dry ☐ Moist ☐ Dusky ☒ Pink ☐ Pale ☐ Flushed ☐ Normal for race	☒ Unlabored ☐ Labored ☐ Cough ☐ Dyspnea ☐ O2 in use @ L/NC	☐ Calm ☐ Cooperative ☐ Anxious ☐ Tearful ☐ Support given



Pediatric Illness

Perry Memorial Hospital

Printed:

11/18/2013 07:59

Time/Date Seen
(If Different):

Mode of

Arrival:

☐ EMS☐ Other

Instructions:

Circle pertinent positive findings

Backslash pertinent negative findings

INDICATORS: * HQI ▲ PQRS

Vital Signs:

Stable except: BP

Pulse

R Rate

Temp

Pulse Ox:

Normal Hypoxic Not Applicable

% on

Room Air

or O₂ @

L/min

Cardiac Monitor:

Rate: NSR Brady Tachy

Rhythm:

Sinus Afib Junctional

Ectopy:

None

PVCs

PACs

STORY:

HX from Patient

Unobtainable due to:

Altered Mental Status

Extremis

Unaccompanied

HX from: Patient

Family / Caretaker

EMS

Interpreter

Medical Records

LMP:

CHIEF COMPLAINT:

This is a

9

month / year old

male / female

who presents with a complaint of:

Fever

Ill-Appearance

(Circle if Appropriate)

ONSET/DURATION

Started

1

Min Hours

Days

Weeks

Agg

Still Present

Resolved

Worse Since:

TIMING

Constant

Intermittent Episodes Lasting

Sec

Min Hours

Days

Weeks

SEVERITY

Max Temp:

F / C

Unknown

Initially:

Mild

Moderate

Severe

Currently:

None

Mild

Moderate

Severe

LOCATION

Associated Pain:

None

Diffuse

Discrete @:

Throbbing

Unable to Describe

Radiates to:

CHARACTER

Sharp

Dull

Aching

Throbbing

Unable to Describe

AGGRAVATING

Position

Movement

Feeding

ALLEVIATING

Antipyretics

Bronchodilators

OTC Meds:

Dose / Time:

Nothing

ASSOCIATED

Negative

Fever

Decreased Activity

Lethargy

Irritability

Rash

SIGNS AND

Nasal Congestion

Ear / Mouth / Throat Pain

Cough

Wheezing

Difficulty Breathing

SYMPTOMS

↓ Oral Intake

Abdominal Pain

Vomiting

Diarrhea

Dysuria

RELATED HX

Similar Episode / Dx as:

Recent Tick Bite / Exposure

Serious Bacterial Infection

Risk Factors:

(Meningitis / Sepsis / UTI)

Negative

Age ↓ 3 Mo:

Neonate

Prematurity

Positive Maternal Group B Strep Culture / Peripartum Maternal Antibiotics

Age ↑ 3 Mo:

Unimmunized

Sickle Cell Disease / Immune Deficiency

UTI:

Prior UTI

Female ↓ 2 Years

Male ↓ 6 Months or Uncircumcised

Antibiotics / HSV

REVIEW OF SYSTEMS:

Pertinent Positives

Constitutional Negative

Eyes Negative

T Negative

Respiratory Negative

GI Negative

GU Negative

MS Negative

Skin Negative

Neuro Negative

Psych Negative

Fever

Chills

Decreased Activity

Discharge

Redness

Ear / Mouth / Throat Pain

Rapid Heart Rate

Cool Extremities

Cough

Wheezing

Difficulty Breathing

Vomiting

Diarrhea

Poor Feeding

Dysuria

Decreased Urinary Frequency

Extremity Disuse

Swelling

Rash

Cyanosis

Lethargy

Irritability

Seizures

Abnormal Interaction w/Parents (specify)

Additional Pertinent History:

PCP / Managing Physician(s):

Referred to ED / Clinic by: PCP / Telephone Referral / Other:

Previous Visit for Same Complaint to ED/Clinic/PCP/In-Patient Within

72 hours / Days Dx / Rx:

Current Antibiotic(s): None

Acetaminophen / Ibuprofen Dose / Time:

All other systems reviewed and negative: Yes No

Levels 2 - 3: 1 System

Level 4: 2 Systems

Level 5: 10 Systems / Disclaimer

PAST MEDICAL HISTORY:

Previously Healthy

Birth Weight:

Lbs / Kg

PMH / FH / SH: Levels 1 - 3: 0 Level 4: 1 Level 5: PMH plus FH or SH

Birth History

Immunizations

ENT

Respiratory

GI / GU

Chronic Illness

Surgical History

Normal

None

None

None

None

None

None

None

None

None

None

None

None

Normal

Not UTD

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

Abnormal

Not UTD

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

HIB

PneumoCV

Pertussis

Rotavirus

Synagis®

Asthma

Bronchiolitis / RSV

Pneumonia

GERD

UTI

Seizure Disorder

DM I

Sickle Cell Disease

Cerebral Palsy

Ear Tubes

T & A

Splenectomy

V-P Shunt

Indwelling Central Venous Catheter

Indwelling Central Venous Catheter

Prematurity

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

01333591

KRAMER MADELINE H

20509 2300 N AVE

DR CERNOVICH

DR

778905

F 9M

OHIO

DR NO DOCTOR

11/18/13 B/D 01/20/13

P/T-EMEF

IL



Pediatric Illness

Perry Memorial Hospital

PHYSICAL EXAMINATION:

EXAM LIMITED DUE TO: Uncooperative Altered Mental Status Extremis Other:

Appearance

Normal

Normal Findings:

Well-Appearing
No Pain Distress
No Respiratory Distress
Conjunctiva Clear
Ears Normal
Nose Normal
Mouth Normal / Moist MMs
Throat Normal

Abnormal Findings:

Ill-Appearing: Mild Mod Severe
Pain Distress: Mild Mod Severe
Resp. Distress: Mild Mod Severe
Conjunctiva Inflamed / Discharge
TM Erythema / Bulging / Immobility
Nasal Clear / Purulent Drainage
Dry MMs / Lesions
Erythema / Exudate / Enlarged Tonsils

Complaint-Specific Findings

Ill Appearance: Yes ☒ No
Altered Mental Status: Yes ☒ No

Anterior Fontanelle:
Closed Flat Bulging Sunken

Meningeal Signs:

Nuchal Rigidity: Yes ☒ No
Brodzinski's Sign: Yes ☒ No
Kernig's Sign: Yes ☒ No

Retractions: Nasal Flaring
Supraclavicular
Intercostal
Diaphragmatic
Grunting Respirations
Inadequate Effort

Extremity Disuse @

Joint Swelling @
Skin Rash: Petechial Purpuric
Macular Papular
Vesicular Urticarial
Erythema Warmth

Neck

Normal

Supple
Nontender
No Lymphadenopathy
Airway Patent
CTA

Nuchal Rigidity
Tenderness @
Enlarged Nodes @
Airway Obstructed / Stridor
Crackles @
Wheezes @
Breath Sounds @
Retractions

Respiratory

Normal

Breath Sounds Equal
Respiration Nonlabored

Cardiovascular

Normal

RRR
No Murmur
Pulses Normal
Brisk Capillary Refill

Tachycardia Bradycardia
Murmur: Grade / VI Systolic Diastolic
Distal Pulses: Weak Absent
Delayed Capillary Refill

GI / GU

Normal

Soft / Nontender
No Masses
Bowel Sounds Normal
No Organomegaly

Tender @ mild diffuse
Mass @
Bowel Sounds Hypo Hyper
Hepatomegaly / Splenomegaly

Musculoskeletal

Normal

Strength / ROM Intact
No Edema

Limited @
Edema @

Skin

Normal

Warm & Dry
No Rash
Color Normal

Pale / Diaphoretic
Rash (specify):
Cyanosis @

Neuro

Normal

Alert
Muscle Tone Normal

Fatigued / Lethargic / Unresponsive
Muscle Tone

Psychiatric

Normal

Response to Family:
Age Appropriate

Response to Family:
Decreased / Consolable / Inconsolable

Level 1: 1 System
Levels 2 - 3: 2 Systems
Level 4: 4 Systems
Level 5: 8 Systems

DIFFERENTIAL DIAGNOSES / HQI / PQRS:

Consideration of the
following conditions may be warranted for the presenting problem; they are not final diagnoses

Otitis Media

Neonatal Herpes

Bacteremia

Pharyngitis / Stomatitis

Bronchitis / Bronchiolitis

Pneumonia

Gastroenteritis

Pyelonephritis / UTI

Hypoglycemia

URI / Viral Syndrome

Meningitis

Rocky Mountain Spotted Fever

Other:

RE-EVALUATION:

Time: _____ Unchanged Improved Worse VSS Pain Scale (0-10)

Time: _____ Unchanged Improved Worse VSS

PHYS. NOTIFICATION/CONSULTS: Chart Copy Available to Add'l Care Providers

Discussed case/management/disposition of patient with:

Name: _____ at _____ a.m. / p.m.

Name: _____ at _____ a.m. / p.m.

Admit/Transition Orders Written by ED Provider: Yes / No

Reviewed with:

Admit to: _____ Consult Follow-up:

DISPOSITION: DISPOSITION DECISION TIME:

Discharge: Home Parent/Guardian School Foster Care Deceased AMA

Admit: ED Obs InPt Unit: ICU OR Floor Condition: Stable Unstable

Patient Endorsed To/Discussed With: _____ @ _____ a.m. / p.m.

Patient Stabilized Within Hospital's Capabilities/Transferred to:

Transfer Form Completed

Disposition Rationale:

Discussed with: Patient Family Other:

After-Care Instructions Given to & Follow-Up Care Discussed w/Patient At Discharge

ED PHYSICIAN DIAGNOSES:

1 Erythema perineum
2 diaper rash / dermatitis mild
3

Critical Care Provided: 30-74 min / 75-104 min _____ min

SIGNATURE:

I have reviewed available Ancillary / Nursing Staff documentation.

DISPOSITION TIME:

PA / NP / Resident

MD/DO

MD/DO

SITATION DATE:

(if different than above)

Teaching Physician - I performed a history & physical examination of the patient and discussed the management with the Resident. I reviewed the Resident's note and agree with the findings and plan of care, except as I have documented _____ (Initials)

Chart Completed: Yes No

01333591
KRAMER MADELINE H
20509 2300 N AVE
DR CERNOVICH
DR

778905
F 9M
OHIO
DR NO DOCTOR
11/18/13 B/D 01/20/13

P/T-EMER

IL



**Perry
Memorial
Hospital**

815-875-2811 Extension; 4411

Patient Discharge Instructions

Patient Name KRAMER MADELINE H

Patient Acct. # 013335

MR # 778905

Admitting Physician: CERNOVICH

Secondary Physician: NO DOCTOR

Discharge Instruction/Education Handout(s) given & reviewed:

DIAPER RASH

☒ Written Prescription(s) provided

☐ Prescriptions called to: _____ Pharmacy

Other Instructions:

Medications Received in the ER

☐ Immunizations given

Medication

NONE

Time Given

Drug Information given

☐

☐

☐ MORE

Medications to be Taken at Home

Medication Name	Dose	Route	Frequency	Dispensed
<u>NYSTATIN CREAM</u>	<u></u>	<u>On Skin</u>	<u>APPLY TO PERINEUM 2 TIMES A DAY</u>	<u></u>
<u></u>	<u></u>	<u></u>	<u></u>	<u></u>

☐ MORE

☒ Take prescribed medication(s) as directed. CAUTION: If you develop a rash, or unusual symptoms, contact your physician or the Emergency Department before continuing the medication.

☐ Do not drive, operate machinery or take alcoholic beverages while taking this medication: _____

☐ Due to medication you have been given while in the Emergency Department, your alertness may be somewhat impaired for 6 - 8 hours. Do not drive or operate heavy machinery.

X-RAY AND CULTURE REPORTS

☐ The X-Ray reading today is a preliminary report. The radiologist will review the X-Rays. If there is a change, you will be notified.

☐ The culture that was done today will not have an immediate report available. If there is a change in your treatment, you will be notified.

Patient Name KRAMER MADELINE HPatient Acct. # 013335MR # 778905

Patient Discharge Instructions (continued)

FOLLOW-UP INSTRUCTIONS

Call to arrange an appointment to see Dr. Physician Access Guide given in 1-2 days for follow up care. Tell the office receptionist you were seen in the Emergency Room. Call sooner if you think necessary. Show this instruction sheet to your doctor.

You have been referred to Dr. in days for follow up care. Tell the office receptionist you were seen in the Emergency Room. Call sooner if you think necessary. Show this instruction sheet to your doctor.

NOTE: The examination and treatment you have received have been rendered on an emergency basis only, and are not intended to be a substitute for or an effort to provide complete medical care. Your follow-up doctor (named above) will receive a copy of your records and all test reports. It is important that you let him/her check you again, and that you report to him/her any new or remaining problems at that time, because it is impossible to recognize and treat all elements of injury or illness in a single Emergency Department visit. Meanwhile, FOLLOW THE INSTRUCTIONS BELOW as indicated to you.

RETURN FOR:

- | | |
|--|---|
| ☒ Signs of infection: redness, swelling, increased pain or warmth, red streaks, pus or drainage. | ☐ Dehydration-dry lips or tongue, decrease in urination, no tears when crying. |
| ☒ Fever, chills | ☐ Numbness, weakness or tingling in extremities |
| ☐ Increased pain | ☐ Headache. |
| ☐ Changes in walking, vision or speech. | ☐ Feeling faint or dizziness. |
| ☐ Chest pain | ☐ Shortness of breath or difficulty breathing. |
| ☒ New or worsening symptoms. | ☐ Nausea, vomiting or diarrhea. |
| ☐ Loss of bowel or bladder control. | |

OTHER SPECIFIC INSTRUCTIONS

☐ MORE

CHANGE DIAPER FREQUENTLY

☐ Planning Ahead brochure given to ☐ patient ☐ family ☐ refusedClinical Impression: DIAPER RASH/DERMATITISDischarge VS: NewPain level at time of discharge 0

I hereby acknowledge receipt of and understand the printed and verbal instructions and give permission to have any lab, x-ray or other pertinent information regarding my visit to ER sent to my family/referral doctor.

" Julia Eickmeier

Signature:

Relationship Parent

Date:

111813

Time:

0818

Nurse:

Kathy M., RN



Pediatric Illness

Perry Memorial Hospital

PHYSICAL EXAMINATION:

EXAM LIMITED DUE TO: Uncooperative Altered Mental Status

Extremis Other:

Appearance

Normal

Normal Findings:

Well-Appearing
No Pain Distress
No Respiratory Distress

Abnormal Findings:

Ill-Appearing: Mild Mod Severe
Pain Distress: Mild Mod Severe
Resp. Distress: Mild Mod Severe

Eyes

Normal

Conjunctiva Clear

Conjunctiva Inflamed / Discharge

ENT

Normal

Ears Normal
Nose Normal
Mouth Normal / Moist MMs
Throat NormalTM Erythema / Bulging / Immobile
Nasal Clear / Purulent Drainage
Dry MMs / Lesions
Erythema / Exudate / Enlarged Tonsils

Neck

Normal

Supple
Nontender
No LymphadenopathyNuchal Rigidity
Tenderness @
Enlarged Nodes @

Respiratory

Normal

Airway Patent
CTA
Breath Sounds Equal
Respiration NonlaboredAirway Obstructed / Stridor
Crackles @
Wheezes @
Breath Sounds @
Retractions

Cardiovascular

Normal

RRR
No Murmur
Pulses Normal
Brisk Capillary RefillTachycardia Bradycardia
Murmur: Grade / VI Systolic Diastolic
Distal Pulses: Weak Absent
Delayed Capillary Refill

GI / GU

Normal

Soft / Nontender
No Masses
Bowel Sounds Normal
No OrganomegalyTender @ *mild epigastric*
Mass @ *upper*
Bowel Sounds Hypo Hyper
Hepatomegaly / Splenomegaly

Musculoskeletal

Normal

Strength / ROM Intact
No EdemaLimited @
Edema @

Skin

Normal

Warm & Dry
No Rash
Color NormalPale / Diaphoretic
Rash (specify):
Cyanosis @

Neuro

Normal

Alert
Muscle Tone NormalFatigued / Lethargic / Unresponsive
Muscle Tone

Psychiatric

Normal

Response to Family:
Age AppropriateResponse to Family:
Decreased / Consolable / Inconsolable

Complaint-Specific Findings

Ill Appearance: Yes ☒ No
Altered Mental Status: Yes ☒ NoAnterior Fontanelle:
Closed Flat Bulging Sunken

Meningeal Signs:

Nuchal Rigidity: Yes ☒ No
Brudzinski's Sign: Yes ☒ No
Kernig's Sign: Yes ☒ NoRetractions: Nasal Flaring
Supraclavicular
Intercostal
Diaphragmatic
Grunting Respirations
Inadequate EffortExtremity Disuse @
Joint Swelling @Skin Rash: Petechial Purpuric
Macular Papular
Vesicular Urticarial
Erythema WarmthLevel 1: 1 System
Levels 2 - 3: 2 Systems
Level 4: 4 Systems
Level 5: 5 Systems

DIFFERENTIAL DIAGNOSES / HQI / PQRS:

Consideration of the

following conditions may be warranted for the presenting problem; they are not final diagnoses

Acute Otitis Media

Neonatal Herpes

Bacteremia

Pharyngitis / Stomatitis

Bronchitis / Bronchiolitis

Pneumonia

Gastroenteritis

Pyelonephritis / UTI

Hypoglycemia

URI / Viral Syndrome

Meningitis

Rocky Mountain Spotted Fever

Other: _____

RE-EVALUATION:

Pain Scale (0-10)

Time: _____ Unchanged Improved Worse VSS

Time: _____ Unchanged Improved Worse VSS

PHYS. NOTIFICATION/CONSULTS: Chart Copy Available to Add'l Care Providers

Discussed case/management/disposition of patient with:

Name: _____ at _____ a.m. / p.m.

Name: _____ at _____ a.m. / p.m.

Admit/Transition Orders Written by ED Provider: Yes / No

Reviewed with: _____

Admit to: _____ Consult Follow-up: _____

DISPOSITION: DISPOSITION DECISION TIME:

Discharge: Home Parent/Guardian School Foster Care Deceased AMA

Admit: ED Obs InPt Unit: ICU OR Floor Condition: Stable Unstable

Patient Endorsed To/Discussed With: _____ @ _____ a.m. / p.m.

Patient Stabilized Within Hospital's Capabilities/Transferred to: _____

Transfer Form Completed

Disposition Rationale: _____

Discussed with: Patient Family Other: _____

After-Care Instructions Given to & Follow-Up Care Discussed w/Patient At Discharge

ED PHYSICIAN DIAGNOSES:

1 *Crythema peroneum*
2 *hyper rash / dermatitis mild*
3

Critical Care Provided: 30-74 min / 75-104 min / _____ min

(Excludes time required for other billable procedures)

SIGNATURE:

I have reviewed available Ancillary / Nursing Staff documentation.

DISPOSITION TIME:

DISPOSITION DATE

(If different than above)

PA / NP / Resident

MD/DO

MD/DO

Teaching Physician - I performed a history & physical examination of the patient and discussed the management with the Resident. I reviewed the Resident's note and agree with the findings and plan of care, except as I have documented _____ (Initials)

Chart Completed: Yes No

778905

F 9M

OHIO

DR NO DOCTOR

11/18/13 B/D 01/20/13

01333591
KRAMER MADELINE H
20509 2300 N AVE
DR CERNOVICH
DRThis form is to assist the physician's documentation of clinical care and treatment.
It is not intended to supplant that judgement or create a standard of care.

Acct #: 01333591 MR #: 778905 AGE: 9M DOB: 01202013 DATE: 111813 AdvDir: N

PATIENT: KRAMER MADELINE H Admit Phys: CERNOVICH Second Phys: NO DOCTOR

CHIEF COMPLAINT: PERINEUM RED

Emergency Severity Index: Non-emergent Pain level: 0 ☐ Animal Bite

Triage Date: 11182013 Triage Time: 0852 Triage Nurse: Kathy M., RN Triage location: Room

Time to Waiting: Mode of Arrival: Carried Accompanied by: Parent EMS Service:

☐ LWBS

 MVC

☐ **Pre-Hospital Care:**

Critical Care Start Time

Triage Notes

Height & Weight	18 lbs	oz 8.16 kg	8164.7 g	26 in	.39 m	2 0
-----------------	--------	------------	----------	-------	-------	-----

Height & Weight New

Vital Signs

Temperature	Pulse	Respiration	Blood Pressure	O2 Saturation
98 TEMPORAL SCANNING	136 APICAL	24	11/0 R ARM LYING	98

New

NOTES:

MOTHER GIVES HX OF CHILD'S FATHER WATCHING THE CHILD YESTERDAY AND WHEN THE MOTHE
CHANGED THE BABY'S DIAPER TODAY, PERINEUM RED. MOTHER CONCERNED AND WANTS CHILD S
PERINEUM IS RED. NO BLEEDING NOTED.

☐ MORE Notes

Allergies

see E-MAR for allergy reaction information

ALLERGY

ALLERGY

No Known Drug Allergies

☐ **MORE Allergies**

Mental Status	Skin	Respirations	I
☒ Alert	☒ Warm ☐ Cool ☐ Hot	☒ Unlabored ☐ Labored	☐ Calm
☐ Oriented x3	☒ Dry ☐ Moist ☐ Dusky	☐ Cough ☐ Dyspnea	☐ Anxiol
☐ Confused/Disoriented	☒ Pink ☐ Pale ☐ Flushed	☐ O2 in use @ ☐ L/NC	☐ Suppo
	☐ Normal for race		

Perry Memorial Hospital Emergency Department Physical Assessment

Acct #: 01333591 MR #: 778905 AGE: 9M DOB: 01202013 DATE: 111813 AdvDir N
PATIENT: KRAMER MADELINE H Admit Phys CERNOVICH Second Phys: NO DOCTC
RN: Kathy M., RN Assessment time: 0752

PAIN EVALUATION: ☒ States no pain/Exhibits no signs pain

PMH Pain Management Guide:

REVIEW OF SYSTEMS:

☐ Respiratory

☐ Circulatory/Cardiac ☐ Neurological

☐ Abdominal

☐ GU

☐ Skin

☐ Orthopedic

☐ EENT

☐ Notes:

Perry Memorial Hospital ED Patient Progress Record

Acct #: 01333591 MR #: 778905 AGE: 9M DOB: 01202013 DATE: 111813 AdvDir N
 PATIENT: KRAMER MADELINE H Admit Phys CERNOVICH Second Phys: NO DOCTC

Patient Information

Weight 18 lbs oz 8.16 kg 8164.7 g 26 in .39 m2 0

Weight New

Intake & Output

Intake Enter New Intake

Total Intake from 12/10/13 01:53 - 12/10/13 09:53

Total Intake from this form

Output Enter New Output

Total Output from 12/10/13 01:53 - 12/10/13 09:53

Total Output from this form

IV Site & IV Therapy

IV Start - Site Information

☐ field site maintained

Time	Site	IV/INT	Gauge	Attempts	Nurse	D/C w/catheter intact
						☐ Time
						☐ Time
						☐ Time

Exam Data

Critical Care Start Time

Critical Care Stop Time

RN Exam Time

0752

MD Exam Time

0800

Dr. R. Cernovich

Dr.

Interventions - Treatment Record

Time 0818

☐ back board / c-collar maintained

☐ back board / c-collar removed

☒ VS

☐ Pain level

☐ order(s) received

☐ MD notified:

☐ Ice applied ☐ Neb tx per RT

☐ BG

☐ Xray

☐ Foley

☐ Labs obtained per RN

☐ Labs obtained per ED tech

☐ Labs drawn per Lab

☐ NG ☐ EKG completed ☐ EKG reviewed by MD ☐ IV site(s) patent & clear
☐ Monitor ☐ wound irrigation/cleanse ☐ O2 @ ☐ l/m per ☐
☐ Post mold applied; ☐ steri-strips applied ☐ Ortho ☐
size ☐

☒ NotesCommunication ☐Report given to: ☐

RELEASED WITH INSTRUCTION SHEET AND SCRIPT x1 IN CARE OF MOTHER

VS

New

Time ☐ ☐ back board / c-collar maintained ☐ back board / c-collar removed

☐ VS ☐ Pain level ☐ ☐ order(s) received ☐ MD notified: ☐
☐ Ice applied ☐ Neb tx per RT ☐ BG ☐ Xray ☐
☐ Foley ☐ Labs obtained per RN ☐ Labs obtained per ED tech ☐ Labs drawn per Lab
☐ NG ☐ EKG completed ☐ EKG reviewed by MD ☐ IV site(s) patent & clear
☐ Monitor ☐ wound irrigation/cleanse ☐ O2 @ ☐ l/m per ☐
☐ Post mold applied; ☐ steri-strips applied ☐ Ortho ☐
size ☐

☐ NotesCommunication ☐Report given to: ☐☐ MORE☐ LWBS☐ Transfer Communication / Information**Discharge Information**

Patient Belongings: ☐ Clothing ☐ Watch ☐ Glasses ☐ Dentures ☐ Hearing aid x1 ☐ Hearing aid x2
☐ Wallet/Purse ☐ Home medications Belongings Disposition: ☐ All belongings home

☐ Critical Care entire ED visit Critical Care Stop Time ☐

Physician decision to admit - date & time

Date: ☐

must be MMDDYYYY

Time: ☐☒ Discharge Time-out completed☐ LWBSPatient Disposition: ☐ HomeMode: ☐ CarriedLocation: ☐

IV status:

IV details if applicable

Accompanied By: Parent

Pain Scale: 0

Time of Discharge: 0818

RN

Kathy M., R

Perry Memorial Hospital Emergency Department Triage

Acct #: 01332596 MR #: 778905 AGE: 9M DOB: 01202013 DATE: 110813 AdvDir ☒ N
 PATIENT: KRAMER MADELINE Admit Phys: ASCANO M Second Phys: NO DOCTOR

CHIEF COMPLAINT: POSSIBLE MOLESTATION

Emergency Severity Index: Urgent

Pain level: 0 ☐ Animal Bite

Triage Date: 11.8.2013 Triage Time: 1850 Triage Nurse: Jennifer M., RN Triage location: Room 3

Time to Waiting: Mode of Arrival: Carried Accompanied by: Parent EMS Service:

☐ LWBS

☐ MVC ☐ Pre-Hospital Care:

Critical Care Start Time:

Triage Notes

Height & Weight: 19 lbs 2 oz 8.68 kg 8675 g 29 in .42 m2 Floor Scale

Height & Weight: New
 Vital Signs

Temperature	Pulse	Respiration	Blood Pressure	O2 Saturation
98.6 TEMPORAL SCANNING	102 MONITOR	24	94/62 R ARM SITTING	97

New

NOTES:

PARENT STATES THAT SHE THINKS PT WAS SEXUALLY ASSAULTED BY FATHER 3 MONTHS AGO. MOTHER STATES THAT PT CAME HOME FROM A WEEK AT FATHERS HOUSE AND BEGAN GRABBING HER DIAPER AS IF TRYING TO RUB IT AGAINST HER GENITALS FOR PLEASURE. PARENT STATES THAT HER RESEARCH SHOWS THAT IS A SIGN OF MOLESTATION. PARENT ALSO STATES THAT PTS "VAGINA HOLE" WAS OPENED WIDE AND WAS VERY EXCORIATED AND AT TIMES HAD "WHITE GUNK" AT "VAGINA HOLE OPENING." PARENT STATES THAT REDNESS WAS DIFFERENT FROM DIAPER RASH. NO BRUISES, ABRASIONS, OR LACERATIONS NOTED TO HEAD, NECK, CHEST, ABDOMEN, BACK, LEGS, BUTTOCKS, OR ARMS. ACTIVITY AND DEMEANOR APPROPRIATE FOR AGE. GENITALIA INTACT, SOME REDNESS NOTED TO PREI AREA, VAGINAL OPENING WNL. NO BRUISES NOTED TO PERI AREA.

☐ MORE Notes

Allergies

see E-MAR for allergy reaction information

ALLERGY

ALLERGY

No Known Allergies

☐ MORE Allergies

Mental Status	Skin	Respirations	Psychosocial
☒ Alert ☐ Oriented x3 ☐ Confused/Disoriented	☒ Warm ☐ Cool ☐ Hot ☒ Dry ☐ Moist ☐ Dusky ☒ Pink ☐ Pale ☐ Flushed ☐ Normal for race	☒ Unlabored ☐ Labored ☐ Cough ☐ Dyspnea ☐ O2 in use @ L/NC	☒ Calm ☐ Cooperative ☐ Anxious ☐ Tearful ☐ Support given



Child At Risk

Perry Memorial Hospital

SC

Printed:
11/8/2013 19:11
Time/Date Seen
(if different):
11/8/13Mode of
Arrival:
☐ EMS
☐ Other

Instructions:

Vital Signs:

Circle pertinent positive findings

Backslash pertinent negative findings

INDICATORS: * HQI ▲ PQR

Pulse Ox:

Stable except:

BP

Pulse

R Rate

Temp

Cardiac Monitor:

Rate: NSR

Brady

Tachy

Rhythm:

Sinus

Afib

Junctional

Ectopy:

None

PVCs

PACs

STORY:

HX from Patient Unobtainable due to:

Altered Mental Status

Extremis

Unaccompanied

HX from: Patient

(Family) Caretaker

EMS

Interpreter

Medical Records

LMP:

CHIEF COMPLAINT:

This is a 9 month / year old male / female who presents with a complaint of:

alleged sexual molestation

ONSET/DURATION

Occurred

3

Hours

Days

Weeks

Unknown

TIMING

Single Episode

Multiple Episodes

Unknown

SITE OF INCIDENT

Home

Day Care

School

Public

Other

MECHANISM
REPORTED

Accidental

Physical Assault

Sexual Assault

Neglect

Unknown

Unknown

HOME TREATMENT

RELATED HX

Siblings / Other Children At Residence

Child Protective Services Report Filed By:

2 ??

None

None

Child At Risk
Risk Factors:

Negative

Unexplained Injury / AMS / Shock / Arrest

History Changing / Inconsistent w/Injury / Inconsistent w/Child's Ability
Injury in Shape of Object(s) / Various Stages of Healing Delay in Seeking Treatment

REVIEW OF SYSTEMS:

Pertinent Positives

Constitutional Negative
Eyes Negative
ENT Negative
Respiratory Negative
GI Negative
GU Negative
MS Negative
Skin Negative
Neuro Negative
Psych NegativeFever Chills Decreased Activity
Discharge Redness
Ear / Mouth / Throat Pain
Rapid Heart Rate Cool Extremities
Cough Wheezing Difficulty Breathing
Vomiting Diarrhea Poor Feeding
Dysuria Decreased Urinary Frequency
Extremity Disuse Swelling
Rash Cyanosis
Lethargy Irritability Seizures
Abnormal Interaction w/Parents (specify)

Additional Pertinent History:

PCP / Managing Physician(s):

Referred to ED / Clinic by: PCP / Telephone Referral / Other:

Previous Visit for Same Complaint to ED/Clinic/PCP/In-Patient Within

72 hours / Days Dx / Rx:

Reporting Adult(s):

(Name/Relationship):

Caretaker(s):

(Name/Relationship):

Patient Accompanied by: Mother Father Other:

D. Williams (pediatrician for 11 years)
was notified 3 mos ago - dx as diaper
rash & called DCFS

All other systems reviewed and negative: Yes No

Levels 2-3 1 System Level 4 2 Systems Level 5 10 Systems / Disclaimer

PAST MEDICAL HISTORY:

Previously Healthy

Birth Weight:

Lbs / Kg

Birth History

Normal

Abnormal

Immunizations

UTD

Not UTD

ENT

None

Otitis Media

Pharyngitis

Respiratory

None

Asthma

Bronchitis / RSV

Pneumonia

GI / GU

None

GERD

UTI

Chronic Illness

None

Seizure Disorder

DM I

Sickle Cell Disease

Cerebral Palsy

Surgical History

None

PMH / FH / SH Levels 1-3: 0 Level 4 1 Level 5: PMH plus FH or SH

* Influenza Vaccine Within Last 12 Months

Yes No Unknown

FAMILY HISTORY:

Negative

Asthma

Seizures

Other

SOCIAL HISTORY:

Negative

Exposure to Passive Smoke

Tobacco Exposure

Attends: Day Care/School Lives With: Family/Foster Care/Group Hm

Other:

01332596

KRAMER MADELINE

778905

F 9M

P/T-EMEF

DR ASCANO MAN

DR

DR NO DOCTOR

11/08/13 B/D 01/20/13

Patient Name KRAMER MADELINEPatient Acct. # 0133259MR # 778905

Patient Discharge Instructions (continued)

FOLLOW-UP INSTRUCTIONS

Call to arrange an appointment to see Dr. FAMILY DOCTOR in 1-2 days for follow up care. Tell the office receptionist you were seen in the Emergency Room. Call sooner if you think necessary. Show this instruction sheet to your doctor.

You have been referred to Dr. in days for follow up care. Tell the office receptionist you were seen in the Emergency Room. Call sooner if you think necessary. Show this instruction sheet to your doctor.

NOTE: The examination and treatment you have received have been rendered on an emergency basis only, and are not intended to be a substitute for or an effort to provide complete medical care. Your follow-up doctor (named above) will receive a copy of your records and all test reports. It is important that you let him/her check you again, and that you report to him/her any new or remaining problems at that time, because it is impossible to recognize and treat all elements of injury or illness in a single Emergency Department visit. Meanwhile, FOLLOW THE INSTRUCTIONS BELOW as indicated to you.

RETURN FOR:

- | | |
|--|--|
| ☒ Signs of infection: redness, swelling, increased pain or warmth, red streaks, pus or drainage. | ☒ Dehydration-dry lips or tongue, decrease in urination, no tears when crying. |
| ☐ Fever, chills | ☐ Numbness, weakness or tingling in extremities |
| ☒ Increased pain | ☐ Headache. |
| ☐ Changes in walking, vision or speech. | ☐ Feeling faint or dizziness. |
| ☐ Chest pain | ☐ Shortness of breath or difficulty breathing. |
| ☐ New or worsening symptoms. | ☐ Nausea, vomiting or diarrhea. |
| ☐ Loss of bowel or bladder control. | |

OTHER SPECIFIC INSTRUCTIONS

RestPush fluidsGood hand washing☐ MORE

PEDIATRIC RESOURCE CENTER INFORMATION GIVEN. FOLLOW UP IN 1-2 DAYS.

☒ Planning Ahead brochure given to ☐ patient ☒ family ☐ refusedClinical Impression: DIAPER RASH, ALLEGED MOLESTATION

Discharge VS:

Temperature	Pulse	Respiration	Blood Pressure	O2 Saturation
98.1 TEMPORAL SCANNING	127 MONITOR	22	98/64 R ARM SITTING	97

Discharge VS: NewPain level at time of discharge 0

I hereby acknowledge receipt of and understand the printed and verbal instructions and give permission to have any lab, x-ray or other pertinent information regarding my visit to ER sent to my family/referral doctor.

X *Julia Carline*

Signature:

Relationship

Parent

Date:

110813

Time:

1956

Nurse:

Jennifer M., RN



Child At Risk
Perry Memorial Hospital

Printed:
11/8/2013 19:11
Time/Date Seen
(if Different):
11/8/13

Mode of
Arrival:
☐ EMS
☒ Other

Instructions: Circle pertinent positive findings. Backslash pertinent negative findings. INDICATORS: * HQI ▲ PQRS
Vital Signs: Stable except: BP / Pulse / R Rate / Temp
Pulse Ox: Normal Hypoxic Not Applicable % on Room Air or O₂ @ L/min
Cardiac Monitor: Rate: NSR Brady Tachy Rhythm: Sinus Afib Junctional Ectopy: None PVCs PACs

HISTORY:

HX from Patient Unobtainable due to: Altered Mental Status Extremis Unaccompanied
HX from: Patient (Family) Caretaker EMS Interpreter Medical Records LMP:

CHIEF COMPLAINT:

This is a 9 month / year old male / female who presents with a complaint of: alleged sexual molestation

ONSET/DURATION

Occurred 3 Hours Days Weeks Ago Unknown

TIMING

Single Episode Multiple Episodes Unknown

SITE OF INCIDENT

Home Day Care School Public Other: Unknown

MECHANISM
REPORTED

Accidental Physical Assault Sexual Assault Neglect: Unknown

HOME TREATMENT

RELATED HX

Siblings / Other Children At Residence: None
Child Protective Services Report Filed By: 2 ?? None

Child At Risk
Risk Factors:

Negative Unexplained Injury / AMS / Shock / Arrest History Changing / Inconsistent w/Injury / Inconsistent w/Child's Ability
Injury in Shape of Object(s) / Various Stages of Healing Delay in Seeking Treatment

REVIEW OF SYSTEMS:

Pertinent Positives

Constitutional	Negative	Fever	Chills	Decreased Activity
yes	Negative	Discharge	Redness	
ENT	Negative	Ear / Mouth / Throat Pain		
CV	Negative	Rapid Heart Rate	Cool Extremities	
Respiratory	Negative	Cough	Wheezing	Difficulty Breathing
GI	Negative	Vomiting	Diarrhea	Poor Feeding
GU	Negative	Dysuria	Decreased Urinary Frequency	
MS	Negative	Extremity Disuse	Swelling	
Skin	Negative	Rash	Cyanosis	
Neuro	Negative	Lethargy	Irritability	Seizures
Psych	Negative	Abnormal Interaction w/Parents (specify)		

All other systems reviewed and negative: Yes No

Additional Pertinent History:

PCP / Managing Physician(s):

Referred to ED / Clinic by: PCP / Telephone Referral / Other:

Previous Visit for Same Complaint to ED/Clinic/PCP/In-Patient Within

72 hours / Days Dx / Rx:

Reporting Adult(s): (Name/Relationship):

Caretaker(s): (Name/Relationship):

Patient Accompanied by: Mother Father Other:

D. Watson (pediatrician) - (Husband)
was notified 3 mos ago - dx on Aug 11
with 9 called DCFS

Levels 2 - 3 1 System Level 4: 2 Systems Level 5: 10 Systems / Disclaimer

PAST MEDICAL HISTORY:

Previously Healthy

Birth Weight: Lbs / Kg

PMH / FH / SH. Levels 1 - 3: 0 Level 4: 1 Level 5: PMH plus FH or SH

Birth History	Normal	Abnormal	Prematurity	
Immunizations	UTD	Not UTD	HIB	PneumoCV Pertussis Rotavirus Synagis®
ENT	None	Otitis Media	Pharyngitis	
Respiratory	None	Asthma	Bronchiolitis / RSV	Pneumonia
GI / GU	None	GERD	UTI	
Chronic Illness	None	Seizure Disorder	DM I	Sickle Cell Disease Cerebral Palsy
Surgical History	None			

* Influenza Vaccine Within Last 12 Months.

Yes No Unknown

FAMILY HISTORY:

Negative

Asthma
Seizures
Other

CIAP HISTORY:

Negative

Exposure to Passive Smoke
Infectious Exposure
Attends: Day Care/School Lives With: Family/Foster Care/Group Hm
Other:

01332596
KRAMER MADELINE

778905
F 9M

P/T-EMEF

DR ASCANO MAN
DR

DR NO DOCTOR
11/08/13 B/D 01/20/13



Child At Risk

Perry Memorial Hospital

PHYSICAL EXAMINATION:

EXAM LIMITED DUE TO: Uncooperative Altered Mental Status Extremis Other:

Appearance

Normal

Normal Findings:

Well-Appearing
No Pain Distress
No Respiratory Distress

Abnormal Findings:

Ill-Appearing: Mild Mod Severe
Pain Distress: Mild Mod Severe
Resp. Distress: Mild Mod Severe

Eyes

Normal

Conjunctiva Clear

Conjunctiva Inflamed / Discharge

ENT

Normal

Ears Normal

TM Erythema / Bulging / Immobile

Nose Normal

Nasal Clear / Purulent Drainage

Mouth Normal / Moist MMs

Dry MMs / Lesions

Throat Normal

Erythema / Exudate / Enlarged Tonsils

Neck

Normal

Supple

Nuchal Rigidity

Nontender

Tenderness @

No Lymphadenopathy

Enlarged Nodes @

Respiratory

Normal

Airway Patent

Airway Obstructed / Stridor

CTA

Crackles @

Wheezes @

Breath Sounds Equal

Breath Sounds @

Respiration Nonlabored

Retractions

Cardiovascular

Normal

RRR

Tachycardia Bradycardia

No Murmur

Murmur: Grade / VI Systolic Diastolic

Pulses Normal

Distal Pulses: Weak Absent

Brisk Capillary Refill

Delayed Capillary Refill

GI / GU

Normal

Soft / Nontender

Tender @

No Masses

Mass @

Bowel Sounds Normal

Bowel Sounds Hypo Hyper

No Organomegaly

Hepatomegaly / Splenomegaly

Musculoskeletal

Normal

Strength / ROM Intact

Limited @

No Edema

Edema @

Skin

Normal

Warm & Dry

Pale / Diaphoretic

No Rash

Rash (specify):

Color Normal

Cyanosis @

Neuro

Normal

Alert

Fatigued / Lethargic / Unresponsive

Muscle Tone Normal

Muscle Tone

Psychiatric

Normal

Response to Family:

Response to Family:

Age Appropriate

Decreased / Consolable / Inconsolable

Complaint-Specific Findings

HEENT: Anterior Fontanelle: Closed Flat Bulging
Retinal Hemorrhage

Raccoon Eyes

Battle's Sign

Hemotympanum

Torn Frenulum

Skin:

Ecchymosis

Color: Red Purple Green Yellow Mixed

Soft Tissue Swelling

Abrasion / Laceration / Puncture

Burn: Degree 1 2 3

Describe Pattern or Shape:

See
DiagramGenitalia: Please Refer to Evidence
Collection Kit for Physical Examination
Documentation (if applicable)

Refer to Anatomical Drawings if Appropriate

DIFFERENTIAL DIAGNOSES / HQI / PQRS:

Following conditions may be warranted for the presenting problem they are not final diagnoses

Abdominal Injury

Head Injury

Burn

Injuries at Various Stages of Healing

Contusion

Laceration

Fracture

Neglect

Genital Injury

Other:

RE-EVALUATION:

Time: Unchanged Improved Worse VSS

Time: Unchanged Improved Worse VSS

PHYS. NOTIFICATION/CONSULTS: Chart Copy Available to Add'l Care Providers

Discussed case/management/disposition of patient with:

Name: at a.m. / p.m.

Name: at a.m. / p.m.

Admit/Transition Orders Written by ED Provider: Yes / No

Reviewed with:

Admit to: Consult Follow-up:

DISPOSITION: DISPOSITION DECISION TIME: 19:22

Discharge: Home Parent/Guardian School Foster Care Deceased AMA

Admit: ED Obs InPt Unit: ICU OR Floor Condition: Stable Unstable

Patient Endorsed To/Discussed With @ a.m. / p.m.

Patient Stabilized Within Hospital's Capabilities/Transferred to:

Transfer Form Completed

Disposition Rationale: Referred to Child protective services

Discussed with: Patient Family Other: —

After-Care Instructions Given to & Follow-Up Care Discussed w/Patient At Discharge

ED PHYSICIAN DIAGNOSES:

1. deeper rash
2. alleged molestation
- 3.

Critical Care Provided: 30-74 min / 75-104 min / min

(Excludes time required for other billable procedures)

SIGNATURE:

I have reviewed available Ancillary / Nursing Staff documentation.

PA / NP / Resident

MD/DO

MD/DO

DISPOSITION TIME:

19:22

DISPOSITION DATE:

(if different than above)

11/8/13

Teaching Physician - I performed a history & physical examination of the patient and discussed the management with the Resident. I reviewed the Resident's note and agree with the findings and plan of care, except as I have documented (Initials)

Chart Completed: Yes No

01332596

KRAMER MADELINE

778905

F 9M

P/T-EMEF

DR ASCANO MAN

DR

DR NO DOCTOR

11/08/13 B/D 01/20/13

This form is to assist the physician's documentation of clinical care and treatment. It is not intended to supplant that judgement or create a standard of care.



**Perry
Memorial
Hospital**

815-875-2811 Extension; 4411

Patient Discharge Instructions

Patient Name KRAMER MADELINE H Patient Acct. # 013335 MR # 778905
 Admitting Physician: CERNOVICH Secondary Physician: NO DOCTOR

Discharge Instruction/Education Handout(s) given & reviewed:

DIAPER RASH

☒ Written Prescription(s) provided ☐ Prescriptions called to: Pharmacy

Other Instructions:

Medications Received in the ER

☐ Immunizations given

Medication

Time Given

Drug Information giv

NONE

☐ MORE

Medications to be Taken at Home

Medication Name	Dose	Route	Frequency
<u>NYSTATIN CREAM</u>	<u> </u>	<u>On Skin</u>	<u>APPLY TO PERINEUM 2 TIMES A DAY</u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>

☐ MORE

- ☒ Take prescribed medication(s) as directed. CAUTION: If you develop a rash, or unusual symptoms, contact your physician or the Emergency Department before continuing the medication.
- ☐ Do not drive, operate machinery or take alcoholic beverages while taking this medication:
- ☐ Due to medication you have been given while in the Emergency Department, your alertness may be somewhat impaired for 6 - 8 hours. Do not operate heavy machinery.

X-RAY AND CULTURE REPORTS

- ☐ The X-Ray reading today is a preliminary report. The radiologist will review the X-Rays. If there is a change, you will be notified.
- ☐ The culture that was done today will not have an immediate report available. If there is a change in your treatment, you will be notified.

Patient Name KRAMER MADELINE H

Patient Acct. # 0133359

MR # 778905

Patient Discharge Instructions (continued)

FOLLOW-UP INSTRUCTIONS

Call to arrange an appointment to see Dr. Physician Access Guide given in 1-2 days for follow up care. Tell the receptionist you were seen in the Emergency Room. Call sooner if you think necessary. Show this instruction sheet to your doctor.

You have been referred to Dr. in days for follow up care. Tell the office receptionist you were seen in the Emergency Room. Call sooner if you think necessary. Show this instruction sheet to your doctor.

NOTE: The examination and treatment you have received have been rendered on an emergency basis only, and are not intended to be a substitute for or an effort to provide complete medical care. Your follow-up doctor (named above) will receive a copy of your records and all test reports. It is important that you let him/her check you again, and that you report to him/her any new or remaining problems at that time, because it is impossible to recognize and treat all elements of injury or illness in a single Emergency Department visit. Meanwhile, FOLLOW THE INSTRUCTIONS BELOW as indicated to you.

RETURN FOR:

- | | |
|--|---|
| ☒ Signs of infection: redness, swelling, increased pain or warmth, red streaks, pus or drainage. | ☐ Dehydration-dry lips or tongue, decrease in urination, crying. |
| ☒ Fever, chills | ☐ Numbness, weakness or tingling in extremities |
| ☐ Increased pain | ☐ Headache. |
| ☐ Changes in walking, vision or speech. | ☐ Feeling faint or dizziness. |
| ☐ Chest pain | ☐ Shortness of breath or difficulty breathing. |
| ☒ New or worsening symptoms. | ☐ Nausea, vomiting or diarrhea. |
| ☐ Loss of bowel or bladder control. | |

OTHER SPECIFIC INSTRUCTIONS

☐ MORE

Other: CHANGE DIAPER FREQUENTLY

☐ Planning Ahead brochure given to ☐ patient ☐ family ☐ refused

Clinical Impression: DIAPER RASH/DERMATITIS

Discharge VS:

New

Pain level at time of discharge

0

I hereby acknowledge receipt of and understand the printed and verbal instructions and give permission to have any lab, x-ray or information regarding my visit to ER sent to my family/referral doctor.

" Julia Eickmeier

Signature:

Relationship

Date: Time: Nurse:

Perry Memorial Hospital

Emergency Department Initial Interview

Acct #: 01332596 MR #: 778905 AGE: 9M DOB: 01202013 DATE: 110813 AdvDir N
PATIENT: KRAMER MADELINE H Admit Phys ASCANO M Second Phys: NO DOCTO

RN: Jennifer M., RN Time: 1850 Location: Room 3

Weight 19 lbs 2 oz 8.68 kg 8675 g 29 in .42 m2 Floor Scale

Weight New

Current Medications Taken At Home

- ☐ Pharmacy called for assist with medication list
☐ Dr's office called for assistance with medication list

Medication Reconciliation

☐ Validation

Past Medical History

- ☒ Family provided portions or all of the patient history
☐ Unable to assess portions or all of history due to patient condition
☐ Old records reviewed for portions or all of history due to pt. condition; See account:

Assistive Devices: ☒ None ☐ List

Last Menstrual Period ☒ N/A ☐ Date:

Illnesses

- Cardiac & Circulatory History: ☒ None
Respiratory / Pulmonary History ☒ None
GI / GU History: ☒ None
Musculoskeletal History: ☒ None
Mental Health History: ☒ None
Cancer History ☒ None
Other Medical History: ☒ None

Surgery: ☒ No ☐ Yes ☐ History unknown

History of Tobacco Use: ☒ No ☐ Yes ☐ Household member smokes

Perry Memorial Hospital ED Patient Progress Record

Acct #: 01332596 MR #: 778905 AGE: 9M DOB: 01202013 DATE: 110813 AdvDir N
 PATIENT: KRAMER MADELINE H Admit Phys ASCANO M Second Phys: NO DOCTC

Patient Information

Weight 19 lbs 2 oz 8.68 kg 8675 g 29 in .42 m2 Floor Scale

Weight New

Intake & Output

Intake Enter New Intake

Total Intake from 12/10/13 02:02 - 12/10/13 10:02

Total Intake from this form

Output Enter New Output

Total Output from 12/10/13 02:02 - 12/10/13 10:02

Total Output from this form

IV Site & IV Therapy

IV Start - Site Information

☐ field site maintained

Time	Site	IV/INT	Gauge	Attempts	Nurse	D/C w/catheter intact
		☐		☐		☐ Time
		☐		☐		☐ Time
		☐		☐		☐ Time

Exam Data

Critical Care Start Time

Critical Care Stop Time

RN Exam Time

1850

MD Exam Time

1918

Dr. M. Ascano

Dr.

Interventions - Treatment Record

Time 1850

☐ back board / c-collar maintained

☐ back board / c-collar removed

☒ VS

☒ Pain level 0

☐ order(s) received

☐ MD notified:

☐ Ice applied ☐ Neb tx per RT

☐ BG

☐ Xray

☐ Foley

☐ Labs obtained per RN

☐ Labs obtained per ED tech

☐ Labs drawn per Lab

☐ NG ☐ EKG completed ☐ EKG reviewed by MD ☐ IV site(s) patent & clear
☐ Monitor ☐ Post mold applied; size ☐ wound irrigation/cleanse ☐ O2 @ ☐ l/m per ☐ Ortho ☐ steri-strips applied

☒ NotesCommunication Report given to:

TRIAGE TO ROOM 3.

1918: MD EXAM WITH JENNY M., RN PRESENT.

VS

 NewTime 1956 ☐ back board / c-collar maintained ☐ back board / c-collar removed

☐ VS ☒ Pain level 0 ☐ order(s) received ☐ MD notified:
☐ Ice applied ☐ Neb tx per RT ☐ BG ☐ Xray
☐ Foley ☐ Labs obtained per RN ☐ Labs obtained per ED tech ☐ Labs drawn per Lab
☐ NG ☐ EKG completed ☐ EKG reviewed by MD ☐ IV site(s) patent & clear
☐ Monitor ☐ wound irrigation/cleanse ☐ O2 @ l/m per
☐ Post mold applied; size ☐ steri-strips applied ☐ Ortho

☒ NotesCommunication Report given to: DC INSTRUCTIONS/HEALTH AND DEVELOPMENT IN INFANT AND PRC INFORMATION GIVEN, PAREN
VERBALIZED UNDERSTANDING. DC HOME.☐ MORE☐ LWBS☐ Transfer Communication / Information

Discharge Information

Patient Belongings: ☒ Clothing ☐ Watch ☐ Glasses ☐ Dentures ☐ Hearing aid x1 ☐ Hearing aid x2
☐ Wallet/Purse ☐ Home medications Belongings Disposition: All belongings home☐ Critical Care entire ED visitCritical Care Stop Time

Physician decision to admit - date & time

Date: Time:

must be MMDDYYYY☒ Discharge Time-out completed☐ LWBS

Patient Disposition: Home

Mode: Carried

Location:

IV status: No IV or INT at discharge/transfer IV details if applicable

Accompanied By: Parent

Pain Scale: 0

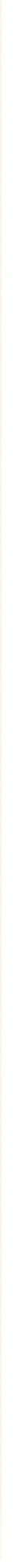
Time of Discharge: 1956

RN Jennifer M.

Name KRAMER MADELINE H Account 01332596

Patient Progress Notes

page 2



Perry Memorial Hospital Emergency Department Physical Assessment

Acct #: 01332596 MR #: 778905 AGE: 9M DOB: 01202013 DATE: 110813 AdvDir N
PATIENT: KRAMER MADELINE H Admit Phys ASCANO M Second Phys: NO DOCTO
RN: Jennifer M., RN Assessment time: 1850

PAIN EVALUATION:☒ States no pain/Exhibits no signs pain

PMH Pain Management Guide: _____

REVIEW OF SYSTEMS:☐ Respiratory☐ Circulatory/Cardiac ☐ Neurological☐ Abdominal☒ GU☐ Skin☐ Orthopedic☐ EENT☐ Notes:GU ☐ Male ☒ FemaleUrinary Symptoms ☒ Normal for pt. ☐ Pain ☐ Frequency ☐ Hesitancy ☐ Urgency ☐ Bloody or dark urine ☐ Incontinent☐ Stress incontinent Last Void: _____ ☐ Distended Bladder ☐ Foley CatheterLast Menstrual Period ☒ Not of age ☐ Post Menopausal ☐ Hysterectomy Approx. 1st day of LMP _____G ☐ P ☐ Ab ☐ EDC _____☐ Vaginal Discharge ☐ Itching ☐ Vulvar/Vaginal Pain ☐ Abnormal Vaginal Bleeding ☐ Passing Clots

Perry Memorial Hospital Emergency Department Triage

Acct #:	01332596	MR #:	778905	AGE:	9M	DOB:	01202013	DATE:	110813	AdvDir	N
PATIENT:	KRAMER MADELINE			Admit Phys	ASCANO M			Second Phys:	NO DOCTC		
CHIEF COMPLAINT POSSIBLE MOLESTATION											
Emergency Severity Index:				Urgent		Pain level		0		☐ Animal Bite	
Triage Date:		11.8.2013		Triage Time:		1850		Triage Nurse:		Jennifer M., RN	
Triage location:		Room									
Time to Waiting				Mode of Arrival:		Carried		Accompanied by:		Parent	
EMS Service:											

☐ LWBS☐ MVC ☐ Pre-Hospital Care:Critical Care Start Time ☐**Triage Notes**

Height & Weight 19 lbs 2 oz 8.68 kg 8675 g 29 in .42 m2 Floor Scale

Height & Weight New

Vital Signs

Temperature	Pulse	Respiration	Blood Pressure	O2 Saturation
98.6 TEMPORAL SCANNING	102 MONITOR	24	94/62 R ARM SITTING	97

New

NOTES:

PARENT STATES THAT SHE THINKS PT WAS SEXUALLY ASSAULTED BY FATHER 3 MONTHS AGO. M STATES THAT PT CAME HOME FROM A WEEK AT FATHERS HOUSE AND BEGAN GRABBING HER DIAF IF TRYING TO RUB IT AGAINST HER GENITALS FOR PLEASURE. PARENT STATES THAT HER RE SHOWS THAT IS A SIGN OF MOLESTATION. PARENT ALSO STATES THAT PTS "VAGINA HOLE" WA OPENED WIDE AND WAS VERY EXCORIATED AND AT TIMES HAD "WHITE GUNK" AT "VAGINA HOLE OPENING." PARENT STATES THAT REDNESS WAS DIFFERENT FROM DIAPER RASH. NO BRUISES, ABRASIONS, OR LACERATIONS NOTED TO HEAD, NECK, CHEST, ABDOMEN, BACK, LEGS, BUTTOC ARMS. ACTIVITY AND DEMEANOR APPROPRIATE FOR AGE. GENITALIA INTACT, SOME REDNESS N TO PREI AREA, VAGINAL OPENING WNL. NO BRUISES NOTED TO PERI AREA.

☐ MORE Notes**Allergies***see E-MAR for allergy reaction information***ALLERGY****ALLERGY**

No Known Allergies

☐ MORE Allergies

Mental Status	Skin	Respirations	I
☒ Alert	☒ Warm ☐ Cool ☐ Hot	☒ Unlabored ☐ Labored	☒ Calm
☐ Oriented x3	☒ Dry ☐ Moist ☐ Dusky	☐ Cough ☐ Dyspnea	☐ Anxiol
☐ Confused/Disoriented	☒ Pink ☐ Pale ☐ Flushed	☐ O2 in use @ ☐ L/NC	☐ Suppo
	☐ Normal for race		



Perry
Memorial
Hospital

815-875-2811 Extension; 4411

Patient Discharge Instructions

MR # 778905

Secondary Physician: NO DOCTOR

Discharge Instruction/Education Handout(s) given & reviewed:

NORMAL GROWTH AND DEVELOPMENT OF IN

☐ Written Prescription(s) provided ☒ Prescriptions called to: _____ Pharmacy

Other Instructions:

Medications Received in the ER

☐ Immunizations given

Medication

Time Given

Drug Information giv

NONE

MORE

Medications to be Taken at Home

Medications to be Taken at Home			
Medication Name	Dose	Route	Frequency

□ MORE

- ☒ Take prescribed medication(s) as directed. CAUTION: If you develop a rash, or unusual symptoms, contact your physician or the Emergency Department before continuing the medication.
- ☐ Do not drive, operate machinery or take alcoholic beverages while taking this medication: _____
- ☐ Due to medication you have been given while in the Emergency Department, your alertness may be somewhat impaired for 6 - 8 hours. Do not operate heavy machinery.

X-RAY AND CULTURE REPORTS

- ☐ The X-Ray reading today is a preliminary report. The radiologist will review the X-Rays. If there is a change, you will be notified.
- ☐ The culture that was done today will not have an immediate report available. If there is a change in your treatment, you will be notified.

Patient Name KRAMER MADELINEPatient Acct. # 013325MR # 778905

Patient Discharge Instructions (continued)

FOLLOW-UP INSTRUCTIONS

Call to arrange an appointment to see Dr. FAMILY DOCTOR in 1-2 days for follow up care. Tell the receptionist you were seen in the Emergency Room. Call sooner if you think necessary. Show this instruction sheet to your doctor.

You have been referred to Dr. in days for follow up care. Tell the office receptionist you were seen in the Emergency Room. Call sooner if you think necessary. Show this instruction sheet to your doctor.

NOTE: The examination and treatment you have received have been rendered on an emergency basis only, and are not intended to be a substitute for or an effort to provide complete medical care. Your follow-up doctor (named above) will receive a copy of your records and all test reports. It is important that you let him/her check you again, and that you report to him/her any new or remaining problems at that time, because it is impossible to recognize and treat all elements of injury or illness in a single Emergency Department visit. Meanwhile, FOLLOW THE INSTRUCTIONS BELOW as indicated to you.

RETURN FOR:

- | | |
|--|--|
| ☒ Signs of infection: redness, swelling, increased pain or warmth, red streaks, pus or drainage. | ☒ Dehydration-dry lips or tongue, decrease in urination, crying. |
| ☐ Fever, chills | ☐ Numbness, weakness or tingling in extremities |
| ☒ Increased pain | ☐ Headache. |
| ☐ Changes in walking, vision or speech. | ☐ Feeling faint or dizziness. |
| ☐ Chest pain | ☐ Shortness of breath or difficulty breathing. |
| ☐ New or worsening symptoms. | ☐ Nausea, vomiting or diarrhea. |
| ☐ Loss of bowel or bladder control. | |

OTHER SPECIFIC INSTRUCTIONS

RestPush fluidsGood hand washing☐ MORE

Other: PEDIATRIC RESOURCE CENTER INFORMATION GIVEN. FOLLOW UP IN 1-2 DAYS.

☒ Planning Ahead brochure given to ☐ patient ☒ family ☐ refused

Clinical Impression: DIAPER RASH, ALLEGED MOLESTATION

Discharge VS:

Temperature	Pulse	Respiration	Blood Pressure	O2 Saturation
98.1 TEMPORAL SCANNING	127 MONITOR	22	98/64 R ARM SITTING	97

Discharge VS:

NewPain level at time of discharge 0

I hereby acknowledge receipt of and understand the printed and verbal instructions and give permission to have any lab, x-ray or information regarding my visit to ER sent to my family/referral doctor.

X *Julia C. Kline*

Signature:

Relationship: Parent

Date:

110813

Time:

1956

Nurse:

Jennifer M., RN